KIRKENDALL DWYER LLP
4343 Sigma RD, STE 200
Dallas, TX 75244
Phone: 877-214-4407 Fax: 214-253-0629
E-Mail: SSDintake@kirkendalldwyer.com
Web: www.kirkendalldwyer.com

RE: Social Security Disability Claim

Dear Client:

Thank you for selecting the Law Offices of Kirkendall Dwyer LLP as your Social Security Disability Attorney. As you already know - **WE ONLY GET PAID IF WE WIN!**

At Kirkendall Dwyer LLP, it is our core legal practice to represent disabled people. It is our mission to guide you through the Social Security Disability process, while providing you with the expertise and compassion you deserve. We have local attorneys throughout the country that work on your claim.

In addition, we understand how important it is for you to receive your disability benefits as quickly as possible. Let our trained staff start working on your disability claim immediately; all we need is for you to provide us with the authorization to start representing you on your disability claim.

If you have any questions about the documents, please contact a Client Specialist at **1-877-214-4407.**

If you do not have any questions, please:

- **SIGN in the HIGHLIGHTED AREAS (use blue ink);**
- **DO NOT date any of the documents; and**
- **RETURN DOCUMENTS in the ENCLOSED ENVELOPE (It is FREE to return the documents)**

Thank you for letting us help you with your Social Security Disability claim.

Sincerely,

Andrew Kirkendall
Kirkendall Dwyer LLP

Claimant's Social Security Number

Appointed Representative's Rep ID

8 Y J D K 7 Q R 4 G

Claimant's Appointment of a Representative

Section 1 - Claimant's Information

Social Security Number

First Name | **Initial** | **Last Name**

Mailing Address

City | **State** | **ZIP/Postal Code** | **Country - if outside the U.S.**

Phone Number

Country/Area Code | Phone Number

Alternate Phone Number (Optional)

Country/Area Code | Phone Number

Number Holder's Information *(Complete when applicable)*

My claim is based on another person's work or earnings (e.g., spouse or parent). This person's information is different from mine.

Number Holder's Social Security Number

First Name | **Initial** | **Last Name**

Section 2 - Disclosure *(Claimant Only)*

X By selecting this box, I, the claimant listed in Section 1, whose signature appears in Section 8, authorize SSA to release information in relation to my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g., clerks, assistants), partners, or parties under contractual arrangements for or with my representative. *(The appointed representative's partners, associates, delegates and designees must be prepared to provide information in order to be authenticated.)*

Section 3 - Principal Representative *(Claimant only – Complete when applicable)*

I have appointed before, or appoint now, more than one representative. I ask SSA to make contacts or send notices to this individual. My principal representative is:

Name Andrew Kirkendall

Claimant's Social Security Number

			-					-				
			-					-				

Appointed Representative's Rep ID

8	Y	J	D	K	7	Q	R	4	G

Section 4 - Representative's Information *(Claimant and Representative)*

Representatives who are eligible and seek direct payment of their fee must register and receive a Rep ID before the appointment. For more information about registration visit us on-line at www.socialsecurity.gov/ar, contact us at 1-800-772-1213 (TTY 1-800-325-0778), or visit your local Social Security office.

Representative's Rep ID

8	Y	J	D	K	7	Q	R	4	G

First Name	Initial	Last Name
Andrew	F	Kirkendall

Mailing Address

4343 Sigma Rd. Suite 200

City	State	ZIP/Postal Code	Country - if outside the U.S.
Dallas	Texas	75244	

Phone Number		Alternate Phone Number (Optional)	
877	214-4407		
Country/Area Code	Phone Number	Country/Area Code	Phone Number

Section 5 - Representative's Status, Affiliations, and Certifications *(Representative Only)*

Representative's Status Part A - Type of Representative (Representatives have a duty to keep their information current)

☒ I am an attorney *(SSA regulation states that an attorney is someone in good standing who has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States.)*

☐ I am a non-attorney eligible for direct payment *(SSA law requires that non-attorneys meet certain criteria to qualify for direct payment. Refer to our website at www.ssa.gov/representation for criteria).*

☐ I am a non-attorney not eligible for direct payment.

Representative's Status Part B - Disqualification

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice law.

☐ Yes ☒ No

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency.

☐ Yes ☒ No

Claimant's Social Security Number: ___ - ___ - ____

Appointed Representative's Rep ID: 8 Y J D K 7 Q R 4 G

Section 5 - Continued *(Representative Only)*

Affiliation Information

If you are representing the claimant(s) as a partner or employee of a business entity, firm or other organization you may provide your Employer Identification Number (EIN) here, if one exists for tax purposes. This number is not your Social Security Number (SSN). This is your employer's tax identification number. (*Do not complete this section if you do not qualify for direct payment.*)

EIN 36-4736133

Organization's Name (Enter the full name of the business, entity, firm or organization with which you want to be affiliated while representing this claim)

Kirkendall Dwyer LLP

Representative's Business Address (if different than mailing address)

City	**State**	**ZIP/Postal Code**

Country - if outside the U.S.

Representative's Certification

I accept this appointment and certify the following:

- I understand and agree that I will comply with SSA's laws and rules on the representation of parties, including the Rules of Conduct and Standards of Responsibility for Representatives; I will not charge, collect, or retain a fee for representational services that SSA has not approved or that is more than SSA approved unless a regulatory exclusion applies.
- I understand that if I fail to comply with any of SSA's laws and rules I may be suspended or disqualified as a representative before SSA.
- I will not disclose any information to any unauthorized party without the claimant's specific written consent.
- I am not currently suspended or prohibited, for any reason, from practicing before the Social Security Administration.
- I am not disqualified from representing the claimant as a current or former officer or employee of the United States.
- I accept appointment as the representative for the claimant named in Section 2 of this form in connection with the claims and asserted rights described in Section 6 of this form.
- I agree that a copy of this signed form SSA-1696 will have the same force and effect as the original.
- I declare under penalty of perjury that I have examined all of the information on this form and on all accompanying statements or forms, including any information, attestations and certifications provided to SSA in registration, and that they are all currently true and correct to the best of my knowledge.

If I intend to seek direct payment of the authorized fee on this claim -

- I have registered for and obtained a Rep ID, and my registration information is up-to-date.
- I have provided up-to-date information on my registration concerning whether I have been suspended or prohibited from practice before SSA or any other Federal program or agency, disbarred or suspended by a court or bar, and convicted of a violation under Section 206 or 1631(d) of the Social Security Act.

I CERTIFY TO ALL OF THE ABOVE  *(Representative's Initials)*

Claimant's Social Security Number

			-					-				
			-					-				

Appointed Representative's Rep ID

8	Y	J	D	K	7	Q	R	4	G

Section 6 - Claim Type *(Claimant or Representative)*

I appoint the individual named in Section 4 to act as my representative in connection with my claim(s) or asserted right(s) under Title II (RSDI), Title XVI (SSI), Title XVIII (Medicare Coverage), and Title VIII (SVB) of the Social Security Act, as presently amended, specifically for the issues identified below: (*Check all that apply*)

- [X] Claim/Appeal for Title II Disability Benefits
- [X] Claim/Appeal for Title XVI Disability Benefits
- [X] Concurrent Title II and Title XVI Disability Benefits
- [ ] Claim/Appeal for Retirement Benefits
- [ ] Claim/Appeal for Title XVIII (Medicare), VIII (Special Veteran's Benefits)
- [ ] Continuing Disability Review (CDR)
- [ ] Post-Entitlement Issue (a new issue you raise after eligibility for other benefits)

_____

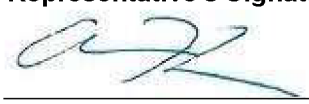
(E.g., benefit amount, month of entitlement, representative payee, suspension, termination, overpayment)

Section 7 - Fee Arrangement *(Representative Only)*

Check one box below:

- [X] **I will request a fee and direct payment of this fee**. Select this box if you are eligible for direct payment and want us to withhold a portion of the past-due benefits to pay you the fee we may authorize. *(We must authorize the fee.)*
- [ ] **I will request a fee but not direct payment.** Select this box if you are not eligible for direct payment from the past-due benefits, or if you do not want direct payment. You must collect any fee we may authorize on your own. *(We must authorize the fee.)*
- [ ] **I waive the right to receive a fee from the claimant, any auxiliary beneficiaries or any other individual.** Select this box if you certify that an entity, or a Federal, state, county, or city government agency will pay the fee and any expenses from its funds. The claimant, auxiliary beneficiaries, or other individuals must not be liable for the fee, directly or indirectly, in whole or in part, or any expenses. *(We do not need to authorize the fee if all regulatory conditions apply.)*
- [ ] **I waive the right to a fee.**

Section 8 - Signatures *(Claimant and Representative)*

Representative's Signature	**Date**
	
Claimant's Signature	**Date**

KIRKENDALL DWYER LLP
4343 Sigma Rd, STE 200
Dallas, TX 75244
Phone: 877-214-4407 Fax: 214-253-0629
E-Mail: SSDintake@kirkendalldwyer.com
Web: www.kirkendalldwyer.com

SOCIAL SECURITY FEE AGREEMENT

FN: 21-355156

I,_____, SSN:_____ , hereby hire Kirkendall Dwyer LLP, to represent me in my claim(s) for Social Security Disability and/or Supplemental Security Income (SSI) benefits. This agreement shall apply to all stages of the application and appeals process with the Social Security Administration.

There is no fee unless I receive a favorable or partially favorable decision for my claim. The firm has not promised that my case will result in a favorable decision. If I do not win any benefits, the Firm will not receive any fees. In consideration of the representation, I agree to have SSA pay the Firm the lesser **of (a) 25% of any past due benefits awarded to me and my family or (b) $7,200 (or such higher limit set by the Commissioner of the SSA pursuant to 206 (a)(2)(A).** I understand that SSA must approve any fee charged by my attorney for services provided in proceedings before the SSA. Claimant also understands and agrees that SSA will withhold the attorney fees from the payment of past due benefits, and SSA will pay such fees directly to the attorney. Under the Social Security Regulations, "past due benefits" include all benefits payable to claimants and/or their families/dependents.

The maximum fee specified in the above paragraph applies if an approval or favorable decision is obtained up to and including the Appeals Council level, however, if a favorable decision is obtained at the Federal level, the Attorney will file a fee petition with SSA, requesting Attorney's fees be approved. If SSA does not approve this fee agreement, Attorney will submit a Fee Petition to the Social Security Administration for approval of a reasonable fee in accordance with the applicable regulations.

I agree to pay all expenses in connection with my case or pay the attorney's law firm back for any such expenses they pay. These expenses include but may not be limited to expenses charged by others, such as for medical reports or special medical/vocational examinations. I hereby give my "power of attorney" to Kirkendall Dwyer LLP and authorize them to request all medical records and sign all appeal documents on my behalf.

I understand that SSA must approve any fee charged by Attorney for services provided in proceedings before the SSA. Claimant also understands and agrees that SSA will withhold the attorney fees from the payment of past due benefits, and SSA will pay such fees directly to the attorney.

I understand that the attorney reserves the right to withdraw from my case or that I may decide I no longer want the attorney to represent me. In either case, I understand the attorney may nevertheless ask the agency to approve a fee for the attorney's time and for any expenses incurred. I understand that by hiring this law firm I am not guaranteed to win my case.

The law firm has given me a copy of this agreement.

SIGNED AND DATED on _____

ACCEPTED AND AGREED TO ON BEHALF OF:

_____ _____

, Claimant **Andrew J. Kirkendall, Esq.**

_____

Co-Representative

Whose Records to be Disclosed	
NAME *(First, Middle, Last, Suffix)*	
SSN	Birthday *(MM/DD/YYYY)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records: also education records and other information related to my ability to perform tasks. This includes Specific permission to release:***

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) including, and not limited to:**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure Signature**	**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)
	(Parent/guardian/personal representative sign here if two signatures required by State law)

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

Signature	**IF** needed, second witness sign here (e.g., if signed with "X" above)
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

KIRKENDALL DWYER LLP
DALLAS HOUSTON

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize _____ to disclose the following information from the health record of:

Patient Name _____ DOB _____
Address _____ DOD _____
City State Zip _____ SSN # (last 4 digits) _____

I authorize the individual or organization listed above to disclose the above-named patient's health information to: Kirkendall Dwyer LLP
4343 Sigma Rd., Ste 200
Dallas, TX 75244
Phone: (214) 271-4027 Fax: (214) 292-6581 Email:
for the purpose of the above-named individual's Social Security/Disability claim.

Date(s) of Service Requested: _____

The information to be disclosed is as follows:

X History & Physical	X Progress Notes/Reports	X Clinic/Office Visit Notes/Reports	
X Consultation Reports	X ER Reports	X Operative Reports	
X Discharge Summary	X X-ray Reports	X Lab Reports	X Psych notes (if applicable)

I understand that the information in the patient's health records may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
My signature below authorizes release of any such information.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I may inspect or copy any information used/disclosed under this authorization.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re- disclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by federal confidentiality rules.

A copy of the consent and a notation as to any action taken thereon is to be entered in the patient's record. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named above. I understand that the revocation of this authorization will not apply to the extent that the healthcare provider has taken action in reliance thereon. I understand that if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

A photocopy of this authorization shall be considered as effective and valid as the original. In the absence of an express revocation, the authority granted under this authorization shall remain in effect for **one year from the date set forth below**. **This authorization does not waive my doctor/patient privilege.**

The information requested by this authorization falls within § 164.512 of the Health Insurance Portability and Accountability Act of 1996.

The undersigned further agrees to waive at any time limitations required by the above provider with respect to their receipt of this authorization and the date on which the authorization was signed.

Date: _____ Signature: _____

Expiration Date: _____ _____
Printed Name

REMARKS (You may use this space for any explanation. If you need more space, attach a separate sheet.)

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

SIGNATURE OF APPLICANT	Date (Month, Day, Year)
Signature (First name, middle initial, last name) (Write in ink)	Telephone Number(s) at which you may be contacted during the day. (Include the area code)

DIRECT DEPOSIT PAYMENT INFORMATION (FINANCIAL INSTITUTION)

Routing Transit Number	Account Number	☐ Checking ☐ Savings	☐ Enroll in Direct Express ☐ Direct Deposit Refused

Applicant's Mailing Address *(Number and street, Apt No., P.O. Box, or Rural Route) (Enter Residence Address in "Remarks," if different.)*

City and State	ZIP Code	County *(if any)* in which you now live

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses. Also, print the applicant's name in Signature block.

1. Signature of Witness	2. Signature of Witness
Address *(Number and street, City, State and ZIP Code)*	Address *(Number and street, City, State and ZIP Code)*

PART 8 - IMPORTANT INFORMATION - PLEASE READ CAREFULLY

34. The Social Security Administration will check your statements and compare its records with records from other state and Federal agencies, including the Internal Revenue Service, to make sure you are paid the correct amount. We have asked you for permission to obtain, from any financial institution, any financial record about you that is held by the institution. We will ask financial institutions for this information whenever we think it is needed to decide if you are eligible or if you continue to be eligible for SSI benefits. Once authorized, our permission to contact financial institutions remains in effect until one of the following occurs: (1) you or your spouse notify us in writing that you are cancelling your permission, (2) your application for SSI is denied in a final decision, (3) your eligibility for SSI terminates, or (4) we no longer consider your spouse's income and resources to be available to you. If you or your spouse do not give or cancel your permission you may not be eligible for SSI and we may deny your claim or stop your payments.

PART 9 - SIGNATURES

35. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

36. Your Signature (First name, middle initial, last name) (Write in ink.)	Date (Month, day, year)

37. Spouse's Signature (First name, middle initial, last name) (Write in ink.) (Sign only if applying for payments.)

WITNESSES

38. Your application does not ordinarily have to be witnessed. If, however, you have signed by mark (X), two witnesses to the signing, who know you, must sign below giving their full address.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and ZIP Code)	Address (Number and Street, City, State, and ZIP Code)

BNC#: _____

Remarks

Use this section to add any information you did not have space for in other parts of the form. Please show the number of the question you are answering.

Signature

I authorize any employer, agency, or other organization to disclose to the Social Security Administration or the State agency that may determine or review my entitlement to disability benefits, any information about my physical and/or mental condition or my work.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of Claimant, Beneficiary or Representative		Date	Area Code and Telephone Number	
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City		State	ZIP Code

If this statement is signed with a mark (e.g., X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses and telephone numbers.

1. Signature of Witness		Date	Area Code and Telephone Number	
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City		State	ZIP Code
2. Signature of Witness		Date	Area Code and Telephone Number	
Mailing Address (Number and Street, Apt. no., P.O. Box, or Rural Route)	City		State	ZIP Code

Claimant's Revocation of the Appointment of a Representative

You, the claimant, can stop your representative from working on your behalf. Complete, sign, and date the section below and submit it to one of our offices. Use a separate form for each appointment you want to revoke. Do not forget to enter your Social Security Number, and if you know it, your representative's identification number (Rep ID).

Claimant's Information

Claimant's Social Security Number

Claimant's First Name	**Initial**	**Last Name**

Claimant's Address

City	**State**	**ZIP/Postal Code**

Representative's Information

Representative's Rep ID

I revoke the appointment of a representative that I previously appointed. I understand that this representative may be entitled to a fee. The representative is:

Name

This was my principal representative. I have appointed multiple representatives and I now name as my new principal representative:

Name

Andrew Kirkendall

Representative's Address

4343 Sigma Rd. Suite 200

City	**State**	**ZIP/Postal Code**
Dallas	Texas	75244

Claimant's Signature	**Date**